VERMONT

HEPATITS C MEDICATIONS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex	Medicaid ID #
	M ☐ F ☐	

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone

Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

icore PHARMACY SERVICES

MedMetrics HealthPartners

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access
HEPATITIS C MEDICATIONS
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

If requesting prescriber is not a Hepatologist, Gastroenterologist or ID Specialist, has one of these specialties been consulted on this case? ☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

Requested OVHA **PREFERRED** Oral Hepatitis C Product?

☐ Ribavirin 200 mg Tab (compare to Copegus®) ☐ Ribavirin 200 mg Cap (compare to Rebetol®)

For any OVHA **NON-PREFERRED** Oral Hepatitis C Product or Strength, please explain the medical necessity for this product:

Product: _____ Medical justification: _____

_____

Requested OVHA **PREFERRED** Injectable Hepatitis C Product?

☐ Pegasys® Prefilled Syringe ☐ Pegasys® Single Dose Vial

For any OVHA **NON-PREFERRED** Injectable Hepatitis C Product, please explain the medical necessity for this product:

Product: _____ Medical justification: _____

_____

4 PRESCRIPTION

Oral:

☐ Ribavirin 200 mg ☐ Tablet or ☐ Capsule

or

☐ Other (Specify): _____

Dose: _____ Frequency: _____ Qty: 28 days supply Refill X:_____

Injectable:

☐ Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box)

or

☐ Pegasys® 180 mcg/1 ml Single Dose Vial

or

☐ Other (choose): ☐ PEG-Intron® RediPen ☐ PEG-Intron® Kit ☐ Infergen®

Specify Strength of above: _____

Sig: Dose/Route/Frequency:_____

Dispense Quantity: 28 days supply Refill X:_____

☐ Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 10/2008